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DATE ISSUED: January 12, 2001

JAMES CARLTON EDWARDS

Claimant

v.

WESTMORELAND COAL COMPANY

Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS

Party-In-Interest

Case No.: 2000-BLA-862

DECISION AND ORDER DENYING REQUEST FOR MODIFICATION

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* (the "Act"). The Act and implementing regulations, 20 C.F.R. parts 410, 718, 725 and 727 (the "Regulations"), provide compensation and other benefits to: (1) living coal miners who are totally disabled due to pneumoconiosis and their dependents; (2) surviving dependents of coal miners whose death was due to pneumoconiosis; and (3) surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death (for claims filed prior to January 1, 1982). The Act and Regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); *see* 20 C.F.R. § 718.201. In this case, the Claimant, James Carlton Edwards, alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on November 30, 2000, in Abingdon, Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice

and Procedure, 29 C.F.R. Part 18. At the hearing, Director's Exhibits 1-70, Claimant's Exhibit 1 and Employer's Exhibits 1-6 were admitted into evidence without objection. Tr. at 11.[1]

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits, the testimony at hearing and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on March 24, 1983. DX 41-1. The claim was denied by Administrative Law Judge ("ALJ") Giles J. McCarthy on July 21, 1989, because the evidence did not establish that the Claimant had pneumoconiosis or any totally disabling respiratory or pulmonary impairment. DX 41-53. The Benefits Review Board affirmed his decision on July 9, 1991. DX 41-62. The Claimant did not appeal the decision further.

More than one year later, on June 10, 1996, the Claimant filed a second, duplicate claim. DX 1. That claim was denied by ALJ Ainsworth H. Brown on March 5, 1998. ALJ Brown found that Mr. Edwards was not suffering from coal worker's pneumoconiosis or any pulmonary impairment arising out of coal mine employment, and, therefore, was not totally disabled by such a disease. DX 50.

Less than one year later, on February 2, 1999, the Claimant filed a request for modification of ALJ Brown's decision. DX 50. The Director issued a proposed Decision and Order denying the request for modification on March 11, 1999. DX 52.

On January 21, 2000, the Claimant filed another request for modification. DX 58. The Director denied the request on March 17, 2000. DX 65. The claim was referred to the Office of Administrative Law Judges for hearing on June 9, 2000. DX 70. Because the underlying claim was filed after April 1, 1980, it is governed by the Regulations at 20 C.F.R. Part 718.

ISSUES

The issues contested by the Employer and the Director are:

1. How long Mr. Edwards worked as a miner.

2. Whether Mr. Edwards has pneumoconiosis as defined by the Act and the Regulations.

3. Whether his pneumoconiosis arose out of coal mine employment.

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[1]The following abbreviations are used for reference within this opinion: DX, Director's Exhibits; CX, Claimant's Exhibits; EX, Employer's Exhibits; Tr., Hearing Transcript; Dep., Deposition. Better copies of five pages of DX 58 were substituted after the hearing in accordance with the agreement of the parties. Tr. at 6-11.

4. Whether he is totally disabled.

5. Whether his disability is due to pneumoconiosis.

6. Whether the evidence establishes a material change in conditions since denial of his initial claim pursuant to 20 C.F.R.§ 725.309.

7. Whether the evidence establishes a change in conditions or that a mistake was made in the determination of any fact in a prior denial of his duplicate claim pursuant to 20 C.F.R. § 725.310.

DX 69; Employer's Pre-hearing Report; Tr. at 5-6

APPLICABLE STANDARD

Pursuant to 20 C.F.R. § 725.310, in order to establish that he is entitled to benefits in connection with his second claim, Mr. Edwards must demonstrate that there has been a change in conditions or a mistake in a determination of fact such that he meets the requirements for entitlement to benefits under 20 C.F.R. Part 718. In order to establish entitlement to benefits under Part 718, Mr. Edwards must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 C.F.R. §§ 718.1, 718.202, 718.203 and 718.204. I must consider all of the evidence pertaining to his second claim to determine whether there has been a change in conditions or a mistake of fact by ALJ Brown; new evidence is not required for me to reach a determination that there has been a mistake of fact. *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254 (1971); *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993). Because the underlying claim is a duplicate claim, in order to be entitled to benefits, Mr. Edwards would also need to establish a material change in conditions since his initial claim was denied. 20 C.F.R. § 725.309(d); *see Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1363 (4th Cir. 1996). Because I find that he has not established a change in conditions, the medical evidence from his initial claim will not be addressed in this decision and order.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

Mr. Edwards testified that he worked nine years in coal mining. Tr. at 13, 22-25. His last job, from 1978 to 1983, was in the central machine shop, where he welded and worked on tipples. He did not do any heavy lifting in that job. Tr. at 15-16. Examples of the work he did included repairing broken tipples by replacing engines and welding holes. He said it was a dusty job, requiring him to blow dust off the tipple with an air hose in order to make repairs. He did not have a respirator. Tr. at 16-17, 27-28. He quit working in the mines in March 1983 because he was taken off work by his

doctor, Doctor Smiddy, because of the condition of his lungs. Tr. at 17-18.

Mr. Edwards said he takes several medications for his breathing, and has been on oxygen off and on. He is still being treated by Dr. Smiddy. Tr. at 18. He said his breathing has worsened since his previous hearing. He could walk a little further then. He gets so out of breath he has to sit down. He spends most of his time watching TV. Sometimes he goes shopping with his wife, and when he feels able, can go up and down the aisles. Tr. at 19-20. He notices his breathing more at night because he "smothers" when he lies down. He receives Social Security, and Westmoreland Coal Company pays for his medications through Virginia Workers' Compensation.[2] Tr. at 20.

Mr. Edwards' last coal mine employment was in Virginia. DX 35. Therefore this claim is governed by the law of the 4th Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

Length of Employment

The Claimant alleged nine years of coal mining employment. Based on records maintained by Westmoreland Coal Company, DX 41-4, ALJ McCarthy found that the Claimant accumulated seven years of coal mine employment, reflecting some breaks in his employment with Westmoreland. DX 41-53. A similar record submitted in connection with the current claim confirms that calculation as to Westmoreland. DX 35. Based on additional employment reflected in Social Security and United Mine Workers records, the Director found 7.85 years of coal mine employment. DX 4, 5, 37. The Employer concurred. Tr. at 5. I find that Mr. Edwards has 7.85 years of coal mine employment.

Material Change in Conditions

In a duplicate claim, the threshold issue is whether there has been a material change in conditions since the previous claim was denied. The first determination must be whether Mr. Edwards has established with new evidence that he suffers from pneumoconiosis or other pulmonary or respiratory impairment significantly related to or aggravated by dust exposure. Absent a finding that he suffers from such an impairment, none of the elements previously decided against him can be established, and his claim must fail, because a living miner cannot be entitled to black lung benefits unless he is totally disabled based on pulmonary or respiratory impairments. Nonrespiratory and nonpulmonary impairments are irrelevant to establishing total disability for the purpose of entitlement to black lung benefits. *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994); *Beatty v. Danri Corp.*, 16 B.L.R. 1-11, 1-15 (1991), *aff'd.* 49 F.3d 993 (3d Cir. 1995). As will be discussed in detail below, the medical evidence filed in connection with his current claim does not establish that the Claimant has pneumoconiosis or any other pulmonary or respiratory impairment which is totally

[2]The Claimant filed for Workers' Compensation in 1983 based on lung disease; the case was settled by an agreement with Westmoreland that characterized his condition as an injury resulting from inhaling fumes rather than as an occupational disease. DX 3.

disabling. Thus I find that he has not established that a material change in conditions has occurred.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The quality standards for chest x-rays and their interpretations are found at 20 C.F.R. § 718.102 and Appendix A of Part 718. The following table summarizes the x-ray findings available in connection with the current claim and requests for modification. Qualifications of physicians are abbreviated as follows: B= NIOSH certified B-reader; BCR= board-certified in radiology; BCP=board-certified in pulmonology; BCI= board-certified in internal medicine. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists. Film quality codes are 1, Good; 2, Acceptable, with no technical defect likely to impair classification of the radiograph for pneumoconiosis; 3, Poor, with some technical defect but still acceptable for classification purposes; and 4 or U/R, Unacceptable. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis."

Exhibit Number	Date of X-ray/ Date Read	Reading Physician Name and Qualifications	Film Quality	ILO-U/C Class.	Interpretation or Impression
EX 3	02/29/00 08/28/00	Dahhan BCP, BCI, B	3		Film completely negative
DX 64	02/29/00 04/15/00	Spitz BCR, B	2		No parenchymal or pleural abnormalities consistent with pneumoconiosis; linear strands at lung base
DX 63	02/29/00 03/24/00	Meyer BCR, B	2		No parenchymal or pleural abnormalities consistent with pneumoconiosis; linear fibrosis scarring both bases suggesting post-inflammatory scarring or sequelae of aspiration

Exhibit Number	Date of X-ray/ Date Read	Reading Physician Name and Qualifications	Film Quality	ILO-U/C Class.	Interpretation or Impression
DX 62	02/29/00 03/21/00	Wiot BCR, B	3		No parenchymal or pleural abnormalities consistent with pneumoconiosis; disc atelectasis both bases
DX 53	02/29/00 03/02/00	Scott BCR, B	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis; few small calcified granulomata due to healed histoplasmosis; focal atelectasis both lower lungs
DX 53	02/29/00 03/02/00	Wheeler BCR, B	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis; minimal discoid atelectasis lower lungs
DX 58	02/29/00 20/29/00	McSharry BCI, BCP			No evidence of pneumoconiosis; mild atelectasis left base
EX 2	04/30/99 08/01/00	Kim BCR, B	2		No parenchymal or pleural abnormalities consistent with pneumoconiosis; several linear atelectasis in bases; small calcified granulomata right apex
EX 1	04/30/99 07/20/00	Wheeler BCR, B	2		No parenchymal or pleural abnormalities consistent with pneumoconiosis; minimal discoid atelectasis or few linear scars in bases and CPAs
EX 1	04/30/99 07/20/00	Scott BCR, B	2		No parenchymal or pleural abnormalities consistent with pneumoconiosis; minimal discoid atelectasis or linear scars bases
DX 60	04/30/99 06/30/99	Meyer BCR, B	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis; calcified granuloma right apex; linear scarring or atelectasis both bases
DX 60	04/30/99 06/08/99	Spitz BCR, B	2		No parenchymal or pleural abnormalities consistent with pneumoconiosis; linear strands at lung bases

Exhibit Number	Date of X-ray/ Date Read	Reading Physician Name and Qualifications	Film Quality	ILO-U/C Class.	Interpretation or Impression
DX 56	04/30/99 06/04/99	Wiot BCR, B	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis; disc atelectasis both bases
DX 55	04/30/99 04/30/99	Dahhan BCP, BCI, B	1	0/0	No parenchymal or pleural abnormalities consistent with pneumoconiosis; atelectasis left base
DX 58	03/17/99 05/18/99	Alexander[3] BCR, B	1	1/1 p/s	Mild hyperinflation; small round and irregular opacities bilaterally, consistent with pneumoconiosis; no pleural abnormalities; linear scarring left lower zone; 5 mm granuloma right upper zone
DX 58	03/08/99 03/08/99	Smiddy BCI			Unusual linear densities in the bases; infiltrates at left base slightly clearer in comparison with 02/22/99
DX 58	02/22/99 02/22/99	Smiddy BCI			Pneumoconiosis, interstitial lung disease, emphysema and new pneumonia at left base
EX 3	02/13/99 08/28/00	Dahhan BCP, BCI, B	1		Film completely negative
DX 64	02/13/99 03/31/00	Spitz BCR, B	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis; linear strands at lung base; questionable nodule right apex
DX 63	02/13/99 03/24/00	Meyer BCR, B	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis; lingular scarring increasing, can't exclude neoplasm

[3]In a cover letter, Dr. Alexander stated, "Changes of simple Coal Worker's Pneumoconiosis are present, although . . . [he] demonstrate[s] low profusion of small opacities."

Exhibit Number	Date of X-ray/ Date Read	Reading Physician Name and Qualifications	Film Quality	ILO-U/C Class.	Interpretation or Impression
DX 54	02/13/99 02/24/00	Wiot BCR, B	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis; disc atelectasis left base[4]
DX 58	01/05/99 01/05/99	Smiddy BCI			Pneumoconiosis and interstitial change; emphysema and old chronic scarring
DX 58	07/09/98 07/09/98	Smiddy BCI			COPD, old pneumoconiosis, old changes of interstitial lung disease
DX 58	03/11/98 03/11/98	Smiddy BCI			Old scarring; new discoid scar left base; interstitial lung disease
EX 3	01/16/98 08/28/00	Dahhan BCP, BCI, B	1		Film completely negative
DX 64	01/16/98 03/31/00	Spitz BCR, B	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis; basilar linear strands
DX 63	01/16/98 03/24/00	Meyer BCR, B	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis; linear fibrosis left base
DX 54	01/16/98 02/24/00	Wiot BCR, B	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis; disc atelectasis left base
DX 58	01/16/98 01/16/98	Cassedy Unknown			Linear density in lingula likely scarring
EX 3	12/28/97 08/28/00	Dahhan BCP, BCI, B	1		Film completely negative
DX 64	12/28/97 03/31/00	Spitz BCR, B	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis; linear strands as lung bases

[4]In his cover letter, Dr. Wiot said that the disc atelectasis varied in degree in the various studies and is not related to coal dust exposure. DX 54.

Exhibit Number	Date of X-ray/ Date Read	Reading Physician Name and Qualifications	Film Quality	ILO-U/C Class.	Interpretation or Impression
DX 63	12/28/97 03/24/00	Meyer BCR, B	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis; linear fibrosis both bases
DX 54	12/28/97 02/24/00	Wiot BCR, B	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis; disc atelectasis both bases
DX 64	09/21/97 03/31/00	Spitz BCR, B	2		Film completely negative
DX 63	09/21/97 03/24/00	Meyer BCR, B	U/R		
EX 3	09/21/97 08/28/00	Dahhan BCP, BCI, B	3		No parenchymal or pleural abnormalities consistent with pneumoconiosis
DX 54	09/21/97 02/24/00	Wiot BCR, B	U/R		
DX 58	03/11/97 03/11/97	Smiddy BCI			Old interstitial lung disease, chronic lung scarring, pneumoconiosis; no change since 03/07/96
EX 3	01/16/97 08/28/00	Dahhan BCP, BCI, B	1		Film completely negative
DX 43	01/16/97 09/15/97	Castle BCP, BCI, B	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis; linear atelectasis left lower zone; few calcified granulomas
DX 34	01/16/97 03/11/97	Spitz BCR, B	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis; linear strands at left lung base
DX 33	01/16/97 03/10/97	Wiot BCR, B	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis; disc atelectasis left base

Exhibit Number	Date of X-ray/ Date Read	Reading Physician Name and Qualifications	Film Quality	ILO-U/C Class.	Interpretation or Impression
DX 32	01/16/97 02/19/97	Shipley BCR, B	2		No parenchymal or pleural abnormalities consistent with pneumoconiosis; focal scar left base
DX 31	01/16/97 01/16/97	Sargent BCP, BCI, B	1	0/0	No parenchymal or pleural abnormalities consistent with pneumoconiosis; streaky atelectasis in the lingulae
DX 58	12/28/96 03/11/97	Cassedy Unknown			Small scattered areas of atelectasis or infiltrate left lung base
DX 17	07/26/96 08/18/96	Cole BCR, B	2		No parenchymal or pleural abnormalities consistent with pneumoconiosis
DX 18	07/26/96 07/26/96	Paranthaman BCI, B	2	0/0	Film completely negative
DX 58 DX 30	03/07/96 03/07/96	Smiddy BCI			Old scarring; old fibrosis; minimal old granulomas; no active process in comparison with 02/28/95
DX 58 DX 30	02/28/95 02/28/95	Smiddy BCI			Old scarring; old basilar fibrosis; minimal old granulomas; element of COPD
DX 58 DX 30	08/30/94 08/30/94	Smiddy BCI			Old scarring; basilar fibrosis; probable element of COPD with interstitial fibrosis superimposed; old atelectasis left lung
DX 58 DX 30	03/03/94 03/03/94	Smiddy BCI			Old scarring; old interstitial scarring; old discoid change at left base
DX 58 DX 30	12/09/93 12/09/93	Smiddy BCI			Old changes as before described
DX 58 DX 30	05/11/93 05/11/93	Smiddy BCI			Old scarring as before noted
DX 58	11/12/92 11/12/92	Smiddy BCI			Bibasilar interstitial fibrosis slightly improved, with old granulomas, underlying pneumoconiosis

Exhibit Number	Date of X-ray/ Date Read	Reading Physician Name and Qualifications	Film Quality	ILO-U/C Class.	Interpretation or Impression
DX 30	01/31/92 01/31/92	Saha Unknown			Mild emphysema; no other significant abnormalities
DX 30	01/27/92 01/27/92	Saha Unknown			Minimal parenchymal process at lung bases, probably chronic; mild emphysema
DX 58 DX 30	12/03/91 12/03/91	Smiddy BCI			Chronic five lobe prominence of interstitial markings; old stable granulomas; old stable scarring at left base
DX 58 DX 30	09/04/91 09/04/91	Smiddy BCI			Changes as described before with slight increased markings at left base
DX 30	03/17/91 03/17/71	Saha Unknown			Lung fields show no infiltrative process; small granuloma right apex; no significant cardiopulmonary disease process
DX 58 DX 30	03/05/91 03/05/91	Smiddy BCI			Old chronic changes; basilar scarring; fibrotic area at left base; old granulomas
DX 58	03/06/90[5] 03/06/90	Smiddy BCI			Stable old chronic changes with interstitial fibrosis and pneumoconiosis

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The following chart summarizes the results of the pulmonary function studies available in connection with the current claim and requests for modification. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. The quality standards for pulmonary function studies are found at 20 C.F.R. § 718.103.

[5]Interpretations of x-rays taken before this date have been omitted because they pre-date the decision of ALJ McCarthy on the previous claim. Some of the omitted x-rays were read by some readers as positive for pneumoconiosis, profusion 1/0.

The standards require that the studies be accompanied by two or three tracings of each test performed. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	MVV Pre-/ Post	FVC Pre-/ Post	Tra- cings	Compre- hension/ Cooper- ation	Qual- ify	Physician Impression
DX 53 02/29/00 McSharry	67 70"	1.94 2.09	65	2.80 3.10	Yes		No	Mild to moderate obstructive lung disease without clear-cut bronchodilator responsiveness
DX 55 04/30/99 Dahhan	66 173 cm	2.33 2.45	66 59	3.40 3.67	Yes	Good/ Good	No	MVV invalid due to poor effort; mild partially reversible obstructive ventilatory defect; no restrictive abnormality
DX 58 03/17/99 Smiddy	66 70"	1.9		3.12	No	Good/ Good	Yes	Patient coughed during entire test; Zaldivar, Dahhan and Renn[6] reported as invalid study (DX 61)
DX 58 03/08/99 Smiddy	66 70"	2.22	69	3.69	Yes	Good/ Good	No	MVV outside 95% confidence level; Patient coughed during all forced maneuvers. Zaldivar reported as valid study; Dahhan as showing mild obstruction; Renn as invalid (DX 61)

[6]Joseph J. Renn, III, M.D., is board-certified in internal and pulmonary medicine and a B-reader. DX 61.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	MVV Pre-/ Post	FVC Pre-/ Post	Tra- cings	Compre- hension/ Cooper- ation	Qual- ify	Physician Impression
DX 58 DX 50 07/09/98 Smiddy	65 68"[7]	2.35	77	3.85	Yes	Good/ Good	No	Zaldivar reported as valid study with only fair effort; Dahhan as valid, normal values; Renn as invalid (DX 61)
DX 58 03/11/97 Smiddy	64 68"	1.90/ 2.47		3.83/ 4.03	Yes	Good/ Good	No	Zaldivar and Dahhan reported as acceptable study compatible with asthma (DX 61)
DX 31 01/16/97 Sargent	64 68"	2.10 2.60	58	3.68 3.86	Yes	Good/ Good	No	Mild obstruction, completely reversible with bronchodilator consistent with asthma; no restriction; MVV outside 95% confidence interval
DX 58 DX 30 08/30/94 Smiddy	61 68"	2.45		3.95	No		No	Fino reported as unacceptable (DX 44)
DX 58 DX 30 12/09/93 Smiddy	61 68"	2.46		3.65	Yes		No	Fino and Zaldivar reported as invalid (DX 44)

[7]The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance of 2" in the recorded height of the miner, I have taken the average height (69") in determining whether the studies qualify to show disability under the regulations. None of the valid tests are qualifying to show disability, whether considering the average height or the heights listed by the physicians who administered the testing.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	MVV Pre-/ Post	FVC Pre-/ Post	Tra- cings	Compre- hension/ Cooper- ation	Qual- ify	Physician Impression
DX 58 11/12/92 Unknown	60 68"	2.30		3.62	Yes		No	
DX 10 07/26/96 Paranthaman	63 68.5"	2.16 2.29	76 82	3.82 3.55	Yes	Good/ Fair	No	Mild to moderate obstructive abnormality; Fino and Hippensteel reported as invalid (DX 44)

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The quality standards for arterial blood gas studies are found at 20 C.F.R. § 718.105. The following chart summarizes the arterial blood gas studies available in connection with his current claim and requests for modification. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b). Mr. Edwards' physicians have recommended against exercise tests. DX 13, 58.

Exhibit Number	Date	Physician	pCO_2 at rest exercise	pO_2 at rest exercise	Qualify	Physician Impression
DX 53	02/29/00	McSharry	36	69	No	Normal
DX 55	04/30/99	Dahhan	35.7	75.6	No	Normal
DX 31	01/16/97	Sargent	36	71	No	Normal

Exhibit Number	Date	Physician	pCO_2 at rest exercise	pO_2 at rest exercise	Qualify	Physician Impression
DX 16	09/27/96	Unknown	37	63	Yes	
DX 14	07/26/96	Paranthaman	37	63	Yes	Ranavaya reported as technically acceptable (DX 15)
DX 30	01/22/92	Unknown	37.5	69	No	

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 C.F.R. §§ 718.202(a)(4). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 C.F.R. § 718.202(a)(4). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 C.F.R. § 718.204(b), (c). Quality standards for reports of physical examinations are found at 20 C.F.R. § 718.104. The record contains the following medical opinions submitted in connection with Mr. Edwards' current claim.

Dr. Smiddy

Joseph F. Smiddy, M.D., has been one of Mr. Edwards' treating physicians since 1983. Dr. Smiddy is board-certified in internal medicine. His interpretations of chest x-rays and pulmonary function tests are reported on the tables above. Dr. Smiddy has diagnosed Mr. Edwards to have pneumoconiosis, chronic obstructive pulmonary disease (COPD), interstitial lung disease, bronchitis and emphysema. Dr. Smiddy has supported Mr. Edwards' application for benefits from the outset, being of the opinion that Mr. Edwards is totally and permanently disabled by respiratory impairment due to pneumoconiosis. Four letters of support from Dr. Smiddy expressing that opinion have been entered into the record in connection with his current claim.

The first, dated June 13, 1996, stated that Mr. Edwards was "one hundred percent totally and permanently disabled based upon chronic obstructive pulmonary disease with old interstitial pulmonary fibrosis and scarring and underlying pneumoconiosis." DX 36.

The next, written March 18, 1997, referred to Mr. Edwards' 14-year history of treatment with bronchodilator medications, home aerosols and home oxygen following a 1983 diagnosis of pneumoconiosis. DX 40.

On January 5, 1999, Dr. Smiddy wrote another letter in support of Mr. Edwards' application for benefits. Dr. Smiddy stated:

> This sixty five year old white male has coal worker's pneumoconiosis well documented over many years. Note the attached chest X-ray reports which document significant coal worker's pneumoconiosis on a serial basis back to 1983. This patient had significant coal dust exposure and has had long-standing coal worker's pneumoconiosis. He has also had an element of superimposed interstitial lung disease and COPD.
>
> A copy of his most recent PFT report is attached and reflects support of his bronchodilator medications which are keeping him alive. The patient has been severely ill at times when off bronchodilators.
>
> The patient's current medications are: Theodur, Ativan, Pepcid, Zyloprim, Vanceril Inhaler, Prednisone, Nitro, Imdur, Nebulizer, Ventolin Inhaler and oxygen.
>
> . . .
>
> This patient has home oxygen which he uses at 2 liters per minute. He formerly smoked but quit in 1968. He must continue all of his present medications in order to maintain his present state of health and prevent prompt hospitalization. This patient has well documented pneumoconiosis with other problems as outlined, and in my opinion, his pneumoconiosis alone would be sufficient to produce one hundred percent total and permanent disability for this patient. . . .

DX 50. The pulmonary function tests and x-ray reports referred to in the letter (except for 1983 and 1984 x-ray reports interpreted as positive for pneumoconiosis, classified 1/0, q/t, which were before Judge McCarthy on the initial claim) are included in the tables above.

On February 8, 1999, Dr. Smiddy wrote a letter to Mr. Edwards, stating:

> This letter is to re-certify to you that I agree with the previous opinion you have on file from Dr. Kelly Taylor concerning the fact that in his opinion and, additionally, in my opinion, you should not undergo a treadmill stress test as a part of any pulmonary or lung evaluation. Such testing

would provide greater risk for you than benefit. It is already known that you are severely disabled, totally and permanently, by pulmonary disease and require oxygen, home aerosol and several medications to maintain marginal function.. If I can assist at any time, do not hesitate to let me know.

DX 58.

Dr. Taylor

Kelly D. Taylor, II, M.D., is a general practice physician who has treated Mr. Edwards. Dr. Taylor wrote two letters in connection with Mr. Edwards' claim. On July 2, 1996, he wrote recommending against treadmill testing as being detrimental to Mr. Edwards' health. DX 13. In a letter dated March 19, 1997, addressed "To whom it may concern," he stated:

> Mr. James C. Edwards has been my patient for a number of years. He has a history of exposure to coal dust while working in and around the mines. At this time he is suffering from severe lung disease and is totally disabled as the result of this. Since he has had a history of exposure to coal dust and is bothered with pulmonary failure, it would be reasonable to assume that this is a cause and effect involved in this situation.

DX 40.

Dr. Boyd

Arthur M. Boyd, M.D., is also one of Mr. Edwards' treating physicians. On March 11, 2000, Dr. Boyd wrote:

> . . .
>
> Mr. Edwards has severe asthmatic bronchitis and chronic pulmonary disease. He visits my office frequently in moderate to severe distress, although he is heavily medicated. He was a previous smoker . . . He was employed as a coal miner from 1975 to 1983 and developed severe asthmatic bronchitis and chronic lung disease during that time. In 1983, he was retired at the request of Dr. Joseph Smitty, pulmonologist in Kingsport, and later received his Social Security Disability in 1983. . . .
>
> I have treated this patient only since September 5, 1997. Most all of his visits have been related to problems with his lungs. Since that time, he has had numerous emergency room visits and admissions to the hospital for treatment of acute exacerbations of his chronic lung disease. He is steroid dependent and is taking Prednisone . . . Theophyline . . . Albuterol aerosol . . . Vanceril, and Ventolin inhaler as well.

> In regard to the questions listed on your letter, I do at least think in part that his problems are due to occupational dust exposure by his history, indicating that he was symptoms [sic] free prior to working in the coal mines. The patient is intermittently oxygen dependent and his breathing impairment has definitely limited his activities of daily living to a almost sedentary lifestyle.
>
> . . .

CX 1.

Dr. Paranthaman

On July 26, 1996, S. K. Paranthaman, M.D., examined Mr. Edwards on behalf of the Director. DX 12. Dr. Paranthaman is board-certified in internal and pulmonary medicine and a B-reader. DX 19. Based upon his examination, which included the taking of occupational and medical histories, physical examination, chest x-ray, blood gas and pulmonary function testing, Dr. Paranthaman diagnosed chronic obstructive pulmonary disease and cardiac murmur, rule out mitral regurgitation. With regard to the cause, he stated, "Chronic obstructive pulmonary disease is due to cigarette smoking. If more than 10 years of coal mine employment is documented, it may have aggravated the condition. Cardiac condition is unrelated to coal mine employment." He termed Mr. Edwards functional impairment "moderate." Because the resting blood gas study met the standard for total disability set forth in the Regulations, he considered Mr. Edwards to be totally disabled from coal mine work.

Dr. Sargent

On January 16, 1997, Dale Sargent, M.D. examined Mr. Edwards on behalf of the Employer. DX 31. Dr. Sargent is board-certified in internal medicine and pulmonary disease. Based upon his examination, which included the taking of occupational and medical histories, physical examination, chest x-ray, blood gas and pulmonary function testing, Dr. Sargent concluded that Mr. Edwards was not suffering from coal worker's pneumoconiosis. The pulmonary function and clinical history were more consistent with asthma than with pneumoconiosis. Dr. Sargent found that Mr. Edwards retained the respiratory capacity to perform his last job in the mines. In a deposition taken on November 3, 1997, Dr. Sargent reiterated these opinions and disagreed with Dr. Smiddy's diagnoses based on the reversibility of Mr. Edwards symptoms with medication. DX 45.

Dr. Dahhan

Abdul Kader Dahhan, M.D., reviewed Mr. Edwards' medical records on several occasions and also examined him on April 30, 1999. Dr. Dahhan is board-certified in internal and pulmonary medicine, and a B-reader. His report on the validity of pulmonary function studies (DX 61) is reported on the table above.

Dr. Dahhan issued a report of his examination of Mr. Edwards on May 7, 1999. DX 55. Mr. Edwards reported working nine years in the mines, ending in 1983. He said he smoked one pack per day for 17 years, but had quit 30 years before the examination. He reported symptoms of a daily productive cough and intermittent wheezing. He was taking Theophyline, Prednisone, Ventolin inhaler, Proventil by nebulizer, Vanceril inhaler, and Imdur. He said he was short of breath on exertion such as walking 100'. He also had chest pain on exertion, eased by rest or nitroglycerin. His medical history included stroke, gout peptic ulcer and anxiety. Examination of his chest showed good air entry with scattered expiratory rhonci and wheeze. Results of arterial blood gas, spirometry and chest x-rays are reported on the tables above. Medical records Dr. Dahhan reviewed are summarized in the report. Based on the examination and review of records, Dr. Dahhan concluded that there were insufficient objective findings to justify a diagnosis of pneumoconiosis, based on a normal clinical evaluation of the chest, variable airway obstruction responsive to bronchodilators, normal lung volumes and diffusion capacity, adequate blood gas exchange and clear chest x-ray. He found Mr. Edwards to have no pulmonary or respiratory disability. Reversibility of his obstructive ventilatory defect weighed against pneumoconiosis as a cause. Dr. Dahhan thought it to be the result of previous smoking and bronchial asthma. He said even if there were radiological evidence of pneumoconiosis, Mr. Edwards retained the respiratory functional capacity to work in his previous job.

Dr. Dahhan prepared another report dated May 12, 2000, after reviewing additional records. He again concluded that there was insufficient objective data to justify a diagnosis of coal workers' pneumoconiosis. He diagnosed a mild obstructive ventilatory defect, with sufficient capacity to continue previous coal mining work. He said the obstructive ventilatory defect was not due to coal dust, stating:

> . . . He has not had any exposure to coal dust since 1983, a duration of absence sufficient to cause cessation of any industrial bronchitis that he may have had. His airway obstruction shows variable response to bronchodilator therapy, this finding is inconsistent with the permanent adverse affects of coal dust on the respiratory system. Furthermore, his family physician is treating him with multiple bronchodilators, indicating that he believes that his condition is responsive to such therapy. This finding is inconsistent with the permanent adverse affects [sic] of coal dust on the respiratory system.

He attributed the airway obstruction to Mr. Edwards' history of smoking and bronchial asthma. He also noted that Mr. Edwards' history of old cerebral vascular accident, coronary artery disease with angina, gout, peptic ulcer disease and anxiety were all unrelated to coal dust exposure. DX 64A.

Dr. Dahhan was deposed on October 11, 2000. Most of his practice consists of care of patients with pulmonary conditions. Dep. at 7. He confirmed that he had examined Mr. Edwards and reviewed his medical records on several occasions. Dep. at 8-9. He opined that Mr. Edwards' symptom of shortness of breath was related to his heart rather than his lungs. Dep. at 12-13. He agreed that the test findings and other data, including treatment with steroids and bronchodilators, indicate that Mr. Edwards has an asthmatic condition. Dep. at 16-17. He said that the available data does not support Dr. Smiddy's conclusion that Mr. Edwards is disabled from a pulmonary standpoint.

Dep. at 18. He said that the amount of data available from 1983 to 2000 made him "reasonably confident" in his conclusions, including that Mr. Edwards does not have either "medical" or "legal" pneumoconiosis; the only finding on the tests given Mr. Edwards indicate hyperactive airway disease or bronchial asthma, which is not related to coal dust exposure. Dep. at 21-23. Dr. Dahhan concluded that although Mr. Edwards might be disabled based on his non-pulmonary health problems, he has only a mild respiratory impairment caused by his asthma, such that he has the respiratory capacity to return to his work in the mines. Dep. at 23-24. EX 5.

Dr. McSharry

Roger J. McSharry, M.D., examined Mr. Edwards on behalf of the Employer on February 29, 2000. DX 53. Mr. Edwards described his occupational history, medical history and symptoms similarly as he had during previous examinations. Dr. McSharry's impressions upon physical examination were that Mr. Edwards had some risk of pneumoconiosis as a result of his nine years in the mines, probable chronic obstructive pulmonary disease with asthmatic component, probable coronary disease and mild reflux symptoms. Dr. McSharry also performed chest x-ray, arterial blood gas and pulmonary function testing, the results of which are reported on the tables above. Dr. McSharry concluded that Mr. Edwards does not have pneumoconiosis based on negative x-ray, and mild to moderate obstructive disease responsive to bronchodilators, which is more consistent with asthma than pneumoconiosis, as well as review of the records over time. He questioned Dr. Smiddy's diagnosis of pneumoconiosis in the absence of objective test results supporting that conclusion. He found the only impairment to be an intermittent one, mainly asthma, which he said was not severe enough to interfere with Mr. Edwards occupationally. Dr. McSharry, too, stated that even if Mr. Edwards were subsequently determined to have pneumoconiosis, it would not change his opinion as to the cause or degree of his respiratory abnormality.

Dr. McSharry was deposed on November 10, 2000. EX 6. Dr. McSharry is board-certified in internal medicine, pulmonary medicine and critical care medicine. Dep. at 3. He is a clinician whose practice is confined to patients with diseases of the lungs. Dep. at 5. Dr. McSharry confirmed that he had examined Mr. Edwards, and reviewed additional records in preparation for the deposition. Dep. at 6-7. Dr. McSharry stated that variable shortness of breath, a symptom described by Mr. Edwards during his examination, "are hallmarks of reversible lung disease which is asthma or asthmatic bronchitis" among other diseases. Dep. at 9. His only significant finding on examination from a cardiopulmonary standpoint was wheezing on forced expiratory efforts. Dep. at 10. The medications Mr. Edwards was taking were generally used for treatment of reversible obstructive lung disease such as asthma and asthmatic bronchitis. Dep. at 11. Arterial blood gas and diffusion capacity studies were in the normal range. Dep. at 13-14. Spirometry showed mild to moderately reduced airflow, with a tendency toward improvement with bronchodilator. Dep. at 14. He disagreed with Dr. Boyd's opinion that Mr. Edwards' asthma was due to coal dust exposure. Dep. at 17. He assessed Mr. Edwards' asthma and pulmonary impairment as "fairly mild.," and said he would not be disabled based on pulmonary impairments. He reiterated that he did not think that Mr. Edwards has pneumoconiosis.

Dr. Zaldivar

George L. Zaldivar, M.D., reviewed Mr. Edwards medical records on behalf of the Employer on several occasions between 1986 and 2000. Dr. Zaldivar is board-certified in internal medicine, pulmonary diseases and sleep disorder medicine, and a B-reader. His report on the results of ventilatory studies (DX 61) is reflected in the above table. Reports he has made in connection with the current claim, in which he opines that the record does not support a finding of pneumoconiosis, include one dated October 10, 1997, DX 44, which is accurately summarized in ALJ Brown's decision.

On June 8, 1999, Dr. Zaldivar reported that he had reviewed additional records. DX 56. He concluded that there was no evidence of pneumoconiosis; that there was a mild, variable respiratory impairment present due to asthma; and that Mr. Edwards was not disabled from his usual coal mine work from a pulmonary standpoint. Finally, Dr. Zaldivar concluded that even if Mr. Edwards had simple pneumoconiosis, it would not change the conclusions regarding his pulmonary capacity and ability to return to work.

In a report dated May 22, 2000, Dr. Zaldivar summarized his previous reviews and described the new records he had reviewed. Based on all the records available to him, he concluded:

> . . . Mr. Edwards, who has had asthmatic symptoms for many years without any evidence of airway obstruction by previous tests, by 1999 had developed airway obstruction of variable degree. At times it was mild and at times, moderate. At times the obstruction was reversible and at times not. The diffusion capacity was normal in most of the tests, even up to his last testing. The chest x-ray failed to show pneumoconiosis. He has been treated by his physician with bronchodilators in what appears to be adequate amounts. Therefore, the diagnosis of asthma is not in doubt . . . It is true that there are some miners who are asthmatics. Those individuals tend to have worse breathing capacity over a period of time than coal miners who are not asthmatic. This has been investigated in some studies . . . findings . . . also show worse breathing capacity in individuals who have hyerresponsive airway disease and who are not coal miners. Coal worker's pneumoconiosis has never been implicated as a cause of asthma.
>
> Taking all of this into consideration, my answer [sic] to your questions are as follows.
>
> 1. There is not sufficient objective evidence to justify a diagnosis of coal worker's pneumoconiosis in this case.
> 2. There is a pulmonary impairment present. The impairment is not attributable to coal worker's pneumoconiosis but it is entirely the result of asthma. From the pulmonary standpoint, according to all of these tests, Mr. Edwards is capable of performing his usual coal mining work or work acquiring [sic] similar exertion. It is, of course, understood that he has to take bronchodilators for the treatment of asthma while performing any kind of work.
> 3. Even if Mr. Edwards had coal worker's pneumoconiosis, which according to all of

> these records he does not have, my opinion regarding the cause of his pulmonary breathing abnormalities and his ability to work would remain the same as I have given here.

DX 68.

Dr. Fino

Gregory J. Fino, M.D., also reviewed Mr. Edwards' medical records on several occasions between 1988 and 2000. Dr. Fino is board-certified in internal medicine and pulmonary disease, and a B-reader. DX 68. His x-ray readings are entered on the table above. In his report dated October 13, 1997, DX 44, he concluded that there was insufficient objective medical evidence to justify a diagnosis of pneumoconiosis. He thought Mr. Edwards had a mild respiratory impairment secondary to asthma which was not disabling.

Dr. Fino's June 7, 1999, report summarized the new records he had reviewed. He again concluded that there was insufficient objective medical evidence to justify a diagnosis of pneumoconiosis. Dr. Fino stated he did not believe that Mr. Edwards suffered from an occupationally acquired pulmonary condition. He stated that Mr. Edwards had a mild respiratory impairment as a result of asthma, but was not partially or totally disabled from returning to his last mining job. He said his opinion regarding the cause and degree of impairment would be no different even if there were radiographic evidence of simple pneumoconiosis. DX 56.

In his report dated May 23, 2000, Dr. Fino summarized the new records he had reviewed, including pulmonary function studies, chest x-rays, medical record reviews by other doctors, and the report of examination by Dr. McSharry. Dr. Fino stated that the new information did not cause him to change any of his previous conclusions, as it was consistent with the diagnosis of asthma, which "is not caused, contributed to, or aggravated by the inhalation of coal mine dust." DX 68.

Dr. Castle

James R. Castle, M.D., also reviewed medical records in this case on behalf of the Employer on several occasions. Dr. Castle is board certified in internal medicine and pulmonary diseases, and a B-reader. DX 68. His x-ray readings are summarized on the table above. He prepared a report dated September 22, 1997, DX 43, and was deposed on November 10, 1997, in connection with the current claim, DX 46. Dr. Castle concluded that Mr. Edwards did not have pneumoconiosis and no significant respiratory impairment. In his opinion, Mr. Edwards was suffering from mild obstructive airways disease due to asthma, which was reversible with medication.

In his report dated June 14, 1999, based on his review of the documents summarized in the report, Dr. Castle again concluded that Mr. Edwards did not suffer from pneumoconiosis. He stated that nine years of exposure to coal dust "would be very questionable as to being significant enough to

cause him to develop coal workers' pneumoconiosis if he were a susceptible host." Two other risk factors for development of lung disease were his history of smoking and bronchial asthma. He found recent x-rays to be negative for pneumoconiosis, and physiologic studies "indicative of only very mild airway obstruction with some degree of reversibility" with results "well above federal disability standards." He attacked Dr. Smiddy's conclusion of disability as being unsupported by objective data, including pulmonary function data attached to his (Smiddy's) report. DX 57.

Dr. Castle's final report is dated May 26, 2000. He recounted his and others' conclusions from previous reports that Mr. Edwards suffers from bronchial asthma, but not pneumoconiosis, and that he is not disabled. He also reviewed new examination reports, radiographic reports, pulmonary function studies, and validation reports. His conclusions that Mr. Edwards does not have pneumoconiosis, and that he is not disabled by a respiratory impairment, were unchanged. He stated that the results of the pulmonary function studies, showing reversible airway obstruction, were consistent with asthma, but not consistent with pneumoconiosis. He also stated that even if Mr. Edwards had a positive x-ray study, the physiological studies did not show evidence of impairment. DX 68.

Dr. Hippensteel

Kirk E. Hippensteel, M.D., examined Mr. Edwards in 1983, and reviewed his medical records on several occasions thereafter on behalf of the Employer. Dr. Hippensteel is also board-certified in internal medicine and pulmonary disease and a B-reader. DX 68. In a report dated October 14, 1997, DX 44, he, too, found no pneumoconiosis or permanent impairment.

In his report dated June 15, 1999, Dr. Hippensteel summarized the medical records he had reviewed and concluded that Mr. Edwards did not have coal workers' pneumoconiosis or any coal dust related disease of his lungs. He also concluded that the findings did not show disability from a pulmonary standpoint. DX 57.

Dr. Hippensteel's last report, dated May 30, 2000, reviewed the findings contained in reports of record reviews and x-ray and pulmonary function reports submitted during the previous year. Dr. Hippensteel stated,

> After reviewing the additional records above the conclusions reached in my prior reports in this case are corroborated. The evidence shows with a reasonable degree of medical certainty that this man does not have coal workers' pneumoconiosis and that he does not have pulmonary function impairment referable to his coal dust exposure. The partially reversible pulmonary impairment found on this man is variable and not of a permanent degree enough to keep him from working at his regular job in the mines. The partial reversibility is against coal workers' pneumoconiosis as a cause, but is consistent with an asthmatic and cigarette smoking history that have nothing to do with his prior coal dust exposure. This means that even if it were stipulated that coal workers' pneumoconiosis were present in this case, then it could still be

> stated that this variable impairment is not consistent with causation from coal workers' pneumoconiosis, and is not impairing enough on a permanent basis to keep him from working at his previous job in the mines with a reasonable degree of medical certainly [sic].

DX 68.

Dr. Spagnolo

Samuel V. Spagnolo, M.D., also reviewed some of Mr. Edwards' medical records, listed in his report dated September 25, 2000. DX 4. Dr. Spagnolo is board-certified in pulmonology and internal medicine. Dr. Spagnolo concluded that "the evidence is not just sufficient but overwhelming that Mr. Edwards does not have any chronic restrictive or obstructive pulmonary disease arising out of coalmine employment." He based this conclusion on the absence of any consistent physical, laboratory or radiographic findings indicating interstitial disease consistent with pneumoconiosis, coupled with intermittent symptoms such as occasional decreased breath sounds and wheezing responsive to therapy. He went on to state, "Mr. Edwards medical history, physical findings, spirometry, blood gas results, chest radiographs, and his response to medications are virtually diagnostic of acute and chronic asthma." He also concluded that Mr. Edwards is not partially or totally disabled based on a pulmonary or respiratory impairment attributable to employment as a miner.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment. For purposes of this definition, a disease "arising out of coal mine employment" includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

20 C.F.R. § 718.201. This definition of pneumoconiosis ("legal pneumoconiosis") encompasses many more diseases than does a clinical diagnosis of coal workers' pneumoconiosis ("medical pneumoconiosis"). *See Barber v. Director, OWCP*, 43 F. 3d 899, 901 (4th Cir. 1995); *Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819, 821-822 (4th Cir. 1995); *Kline v. Director, OWCP*, 877 F.2d. 1175, 1178-1179 (3rd Cir. 1989). In this case, letters from Mr. Edwards' treating physicians and other medical records indicate that he has been diagnosed with pneumoconiosis, COPD, interstitial lung disease and emphysema, all of which can be encompassed within the definition of legal pneumoconiosis. *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

20 C.F.R. § 718.202(a) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in §§ 718.304,[8] 718.305[9] or 718.306,[10] or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that Mr. Edwards has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, he filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may

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[8] Irrebuttable presumption of total disability or death due to pneumoconiosis if there is a diagnosis of chronic dust disease of the lung based on x-rays showing one or more large opacities, biopsy or autopsy showing massive lesions, or diagnosis in accord with acceptable medical procedures of a condition which could reasonably be expected to yield the same results ("complicated pneumoconiosis").

[9] Rebuttable presumption of total disability due to pneumoconiosis for a miner employed for 15 or more years with negative x-rays but other evidence of a totally disabling respiratory or pulmonary impairment. This presumption is not applicable to claims filed on or after January 1, 1982. 20 C.F.R. § 718.305(e).

[10] Applicable only to deceased miners.

establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3rd Cir. 1997).

Pneumoconiosis is a progressive and irreversible disease. As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 483 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward v. Director, OWCP*, 991 F.2d 314, 319-320 (6th Cir. 1993); *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Several of the x-rays pertaining to the current claim in this case either were not read for the presence of pneumoconiosis, or were not classified as required by the Regulations, and are of little or no probative value. DX 30 and 58. Of the available x-rays which have been classified in accordance with the requirements of the Regulations, only one, dated March 17, 1999, has been read by one reviewer, Dr. Alexander, to be positive for pneumoconiosis. The rest have been read as negative by many readers. For cases with conflicting x-ray evidence, the Regulations specifically provide,

> Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 C.F.R. § 718.202(a)(1); *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

All but one of the many chest x-ray interpretations available in connection with the duplicate claim and requests for modification have been found to be negative for pneumoconiosis by well-qualified physicians, including pulmonologists, radiologists, and B-readers. There is no basis in the record to discount those overwhelmingly negative readings. Mr. Edwards cannot be found to have pneumoconiosis on the basis of the x-ray evidence.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields, supra.* Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWCP*, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration in . . . weighing . . . the medical evidence . . ." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994).

In this case, three of Mr. Edwards' treating physicians have opined that he has or may have pneumoconiosis and is disabled by it. None of those opinions, however, is well-documented or well-reasoned. On the contrary, the objective testing simply does not support those opinions, either as to the cause of any respiratory problems, or as to the extent of any impairment. Of the valid pulmonary function tests, only the most recent show obstructive disease not entirely reversible by bronchodilators. Although two 1996 blood gas studies resulted in qualifying values, three more recent studies have not. One examiner, Dr. Paranthaman, gave an equivocal opinion that Mr. Edwards' lung disease "may have been aggravated" by coal dust, if he was employed in the mines for more than ten years, which he was not. Since then, Mr. Edwards has been examined repeatedly by pulmonary experts who have opined that he does not have pneumoconiosis and is not disabled by any respiratory or pulmonary impairment (Sargent, Dahhan and McSharry). Their opinions are supported by equally well qualified doctors who have reviewed Mr. Edwards' medical records extensively (Zaldivar, Fino, Castle, Hippensteel and Spagnolo). I find that their opinions are entitled to greater weight, and conclude that the evidence does

not establish that Mr. Edwards has pneumoconiosis.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 20 C.F.R. § 718.203(b). Mr. Edwards was employed as a miner for only seven to eight years, and therefore would not be entitled to the presumption. Because I have concluded that the evidence does not establish that Mr. Edwards has pneumoconiosis, however, this issue is moot.

Total Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 20 C.F.R. § 304, or if pneumoconiosis prevents him from doing his usual coal mine employment or comparable and gainful employment, 20 C.F.R. § 204(b). The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 C.F.R. § 718.204(b). In a living miner's claim, however, lay testimony "is not sufficient, in and of itself, to establish total disability." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that Mr. Edwards suffers from complicated pneumoconiosis or cor pulmonale. As is discussed above, no valid pulmonary function studies, and no recent blood gas studies, show total disability, and the weight of medical opinions is against disability based on the condition of his lungs.

Although Mr. Edwards has testified that he would be unable to return to his employment, I cannot base a finding of disability solely on his testimony. I find that the opinions of Drs. Sargent, Dahhan and McSharry, that Mr. Edwards does not have a pulmonary or respiratory disability, are consistent with the weight of the medical evidence as a whole, including the pulmonary function and arterial blood gas studies. Thus I conclude that Mr. Edwards has failed to establish that he is totally disabled by a pulmonary or respiratory impairment. Because Mr. Edwards has not established either that he has pneumoconiosis, or that he is totally disabled by a pulmonary or respiratory impairment, he cannot establish any of the essential elements for entitlement to benefits.

Causation of Total Disability

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis is a "contributing cause" to his disability. *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990). As I have found that the evidence does not establish either that Mr. Edwards has pneumoconiosis, or that he is disabled, he cannot establish that pneumoconiosis is a contributing cause his disability.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that there has been a change in conditions or a mistake in determination of fact in the decision on his duplicate claim, or that there has been a material change in conditions since the denial of his previous claim, he is not entitled to benefits under the Act.

ATTORNEY'S FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The request for modification filed by James Carlton Edwards on January 21, 2000, is hereby DENIED.

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Alice M. Craft
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Order may appeal to the Benefits Review Board within 30 days from the date of this Order by filing a Notice of Appeal with the Benefits Review Board, 200 Constitution Ave., NW, Washington, D.C. 20210. A copy of a notice of appeal must also be served on Donald Shire the Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N2605, 200 Constitution Ave., NW., Washington, D.C. 20210